Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2022-2023

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To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people.

Our values

We place people at the heart of what we do. We are:

- **Independent** – we are impartial, deciding what work we do and where we do it.
- **Objective** – we are reasoned, fair and evidence driven.
- **Decisive** – we make clear judgements and take action to improve poor standards and highlight the good practice we find.
- **Inclusive** – we value and encourage equality and diversity through our work.
- **Proportionate** – we are agile, and we carry out our work where it matters most.

Our goal:

- To be a trusted voice which influences and drives improvement in healthcare.

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use, and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety.
- We will work collaboratively to drive system and service improvement within healthcare.
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

1. Executive Summary

This report sets out Healthcare Inspectorate Wales (HIW) activity and findings for mental health and learning disability services during the period April 2022 to March 2023

Mental health and learning disability services continue to face many challenges that are affecting outcomes for patients. There continues to be severe pressure on in-patient beds and there are many challenges faced by the health boards and independent providers of care in providing a range of diverse services to vulnerable patients. This year we have extended our inspection programme to include community services.

One positive aspect of the vast majority of our inspections was the appreciation by patients and relatives of the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving. In addition, in the vast majority of our inspections, we found a number of good examples of patients being actively engaged with a range of therapies that they commented positively upon. This is a significant improvement on our previous years of inspection findings where we identified a number of issues with provision of meaningful activities.

However, some areas continue to cause concern for us, particularly where there has been little or no improvement since our 2021-22 report. These areas are:

- Workforce challenges – issues with recruitment and retention of staff.
- Medicines management – a range of issues with the storage, administration, and audit.
- Patient observations – training of staff, lack of effective recording, and the timely review of policies/procedures.
- Patient information – lack of information available for patients on key topics.
- Risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review.
- Environment of care – a lack of audits and the management of environmental ligature risks.
- Governance - a lack of audit and oversight of key areas including training.

In some of our visits we identified very serious issues that required immediate assurance notices for health boards, or non-compliance notices for the independent providers. The health board/independent provider responds to these notices with an immediate improvement plan that HIW must agree. We issued a total of seven notices between the period 1 April 2022 and the 31 March 2023. This comprised of five for health boards and two for the independent providers.

Chapter 6 of this report identifies the process and areas we focus upon to be assured that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

Our findings are drawn from inspection visits and onsite focussed reviews, analysis of information received through our concerns and notifications processes, and the work of our Review Service for Mental Health (RSMH). During the reporting period we conducted a total of 22 onsite inspections to a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- Child and Adolescent Mental Health Services (CAMHS).

Within the total of 22 onsite inspections, we jointly visited three Community Mental Health Teams (CMHTs) with Care Inspectorate Wales (CIW) and one independent healthcare provider was visited on two occasions because of the nature of the concerns identified.

We reviewed 902 regulatory notifications of incidents that occurred within independent mental health and learning disability healthcare settings.

In addition, we received 694 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This represents a decrease in requests from 759 for the period April 2021 to March 2022.

These requests can be broken down in the following way:

- 640 requests related to the certification of medication.
- 42 requests related to the certification of Electro-Convulsive Therapy (ECT).
- 12 requests related to medication and ECT.

In conclusion, we continue to identify areas of good practice and patients continue to be complimentary about the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving. However, we continue to identify significant issues with the workforce, medicines management, patient observations, patient information, risk assessments and care and treatment planning documentation, environment of care and governance.

2. Context

Throughout 2022-23 mental health and learning disability hospitals and community services faced many challenges in delivering services post the COVID-19 pandemic. Many individuals have experienced deterioration in their mental health after the stress and social isolation of living through the pandemic.

This unprecedented event has also placed a considerable degree of pressure on staff working in the NHS and independent sector. Workforce challenges in the recruitment and retention of skilled, knowledgeable, and experienced staff is an issue that made delivering effective services very hard, and inevitably, this impacted on individual patient care and treatment. Workforce issues were found in most of our inspections and effected all disciplines of healthcare staff. Shortages of staff were having an impact on the care pathway for patients particularly in terms of taking section 17 leave which is a key part of a patients' care pathway.

During the inspection year we have undertaken some joint working with CIW visiting three CMHTs. This enabled us to effectively case track joint working between in-patient wards and community services. In addition, we undertook a local review of discharge arrangements for adult patients from inpatient mental health services in Cwm Taf Morgannwg University Health Board. This resulted in a number of significant recommendations being made to the health board.

In 2022-23 some key pieces of guidance were introduced, and we assessed, through our inspections, how health boards and independent providers are implementing the guidance. One key piece of Welsh Government guidance was published in October 2022 and was a framework for reducing restrictive practices in childcare, education, health and social care settings.

The Mental Health Act 1983 Code of Practice for Wales (revised 2016) states "In some exceptional circumstances, where the severity of the patient's behaviour leads to an identification of a need for some form of mechanical restraint, such restraint may, in certain circumstances, be agreed by the hospital managers. This will be in circumstances where a high security placement has been assessed as not being suitable and following a recorded multi-disciplinary discussion. This agreement should usually be made in collaboration with Healthcare Inspectorate Wales (HIW)". HIW has been consulted regarding the use of mechanical restraint. The use of such restraint in hospitals is very rare but, in the event, it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patient's extreme challenging behaviour.

The SOAD service is now a hybrid model with a mixture of remote and face to face contact with patients who require a second medical opinion under the Act. Whether patients are seen remotely or face to face there is still the requirement for health boards and independent providers of care to send key documentation to us to enable the SOAD to have access to key information in relation to the history and treatment for the patient.

We continue to work with a number of stakeholders for mental health and these stakeholders are listed within section 3 of this report. These stakeholders keep HIW well sighted on current developments, within a range of areas, and we use this intelligence to target and enhance our inspections. Following the end of Welsh Government's Together for Mental Health Delivery Plan in 2022, a new mental health strategy is expected from the Welsh Government in Autumn 2023.

3. Our role in mental health and learning disability care

HIW has a number of key roles within healthcare in Wales which are outlined below:

- We inspect all NHS mental health and learning disability services.
- We are the regulator and inspectorate of all independent mental health and learning disability healthcare services.
- We have a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers.
- We monitor parts 2 and 4 of the Mental Health (Wales) Measure 2010.
- We monitor the implementation of the Deprivation of Liberty Safeguards (DoLS).

Inspection and regulation

During this period, within the NHS, we looked at how services met the Health and Care as well as other relevant standards, in order to check that people receive good quality healthcare.

HIW is the registering body for all independent healthcare providers in Wales. We register, inspect, consider intelligence on complaints and concerns and enforce in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the 25 National Minimum Standards for Independent Health Care Services in Wales.

We made use of a combination of routine on-site and focused inspections during 2022-23. The findings from these inspections are summarised in section 5 of this report. In addition, a list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring use of the Mental Health Act 1983

The Welsh Ministers have a duty to monitor how services discharge their powers and duties in relation to the Mental Health Act 1983. This duty is undertaken by HIW on their behalf. We have extensively revised our Mental Health Act compliance methodology to assist our reviewers who monitor how the health boards and independent providers discharge their duties under the Act. Our Mental Health Act reviewers examine detention paperwork to ensure legal compliance, and consult with the Mental Health Act administrators, employed by Health Boards and independent providers, to gain an insight into how the Act is administered and the governance processes in place. We also have a specific role in relation to the investigation of certain types of complaints. During our inspections we routinely review a number of key areas as outlined within the Mental Health Act 1983 – Code of Practice for Wales (revised 2016), assessing whether:

- Mental Health Act detention paperwork ensures patients are lawfully detained and well cared for.
- Patients are informed about their rights on admission and at regular intervals under section 132 both verbally and in writing and a record of this is maintained in the patients' file.
- Patients are given respect for their qualities, abilities, and diverse backgrounds as individuals, and that their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds are taken into account.

- Section 17 leave is routinely utilised when appropriate and to assist patients in their care/rehabilitation pathway.
- The Mental Health Act Code of Practice for Wales (Revised 2016), that has been prepared and issued under section 118 of the Mental Health Act 1983 is being followed.
- Detailed plans are made for patients before they are discharged from hospital and consider key area such as relapse indicators.

In general, the findings from our inspections of the processes and application of the Mental Health Act were positive, however, we did find a number of areas for improvement. Our findings for the period April 2022 to March 2023 are summarised in section 6 of this report.

Review Service Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

- The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the Mental Health Act, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.
- A review of treatment under Section 61 of the Mental Health Act. When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.
- The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2022 and March 2023 is provided in section 7 of this report.

Monitoring the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 consists of four distinct parts:

Part 1 – Primary mental health support services.

Part 2 – Co-ordination of, and care planning for, secondary mental health service users.

Part 3 – Assessment of former users of secondary mental health services.

Part 4 – Mental health advocacy.

During our inspections we routinely review the care and treatment plans for patients and consider the role of the Care Coordinator. Within section 5 of this report, we have detailed our findings on risk assessment and care planning where we consider various aspects of the Measure. We also consider the role and access for patients to advocacy services.

Monitoring use of the Deprivation of Liberty Safeguards

A separate annual report is published jointly by HIW and CIW on the use of the Deprivation of Liberty Safeguards (DoLS). DoLS is a part of the Mental Capacity Act 2005. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024. However, in early April 2023, the UK Government informed Welsh Ministers of a delay to the implementation of LPS. Between April 2022 and March 2023 HIW was a member of the LPS Implementation and Monitoring group with Welsh Government representatives and other key stakeholders. DoLS can be used when

detention under the Mental Health Act 1983 is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM comprises of organisations from the four nations that make -up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), the Independent Custody Visiting Association, Criminal Justice Inspection Northern Ireland and His Majesty's Inspectorate of Constabulary in Scotland. HIW undertakes joint work with His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

We attend NPM business meetings and will again rejoin the steering committee later in 2023.

Youth Justice Services

In April 2022 HIW joined His Majesty's Inspectorate of Probation (HMI Probation) on the joint inspection of Cardiff Youth Justices Services (YJS). Other inspectorates that participated in the joint review include, CIW, Estyn and HMICFRS. HIW's specific remit was to consider the services received by the YJS from a healthcare perspective. The specific areas that we inspected were access to CAMHS, Speech and Language Therapy, substance misuse and access to physical healthcare. Key members of staff employed by the health board were interviewed as part of this process.

Dementia Partners National Steering Group

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). Within this group each of the health boards provide regional updates to the members of the group, on developments within dementia care for their region.

Attendance at the group provides a rich source of information that we can use to ensure services are implementing the All-Wales Dementia Care Pathway of Standards. It should be noted that the Dementia Action Plan for Wales 2018 – 2022 has been extended following extensive evaluation.

Substance Misuse and Mental Health Deep Dive – Co-occurring Meeting

Throughout 2022-23 HIW attended the above group which is organised by Welsh Government. A number of organisations attend this group including, health boards, the National Strategic Clinical network for Mental Health, NHS Executive, representatives of the Royal College of Psychiatrists and Alcohol Change UK. The group is committed to improving the co-ordination between substance misuse, mental health, housing services and a wide range of other operational delivery partners, with a view to improving current pathways of care for individuals with the most complex needs in order to achieve the most positive outcomes possible.

The group will:

- Review the current strategic landscape in relation to Mental Health and substance misuse services, particularly current barriers to seamless integration.
- Consider actions that can be taken at a strategic level across all delivery agencies. This could include all emergency, mental health, and community substance misuse services across both the statutory sector and Third sector, public health interventions and the Criminal Justice system.
- Continue to reinforce the need to integrate housing services and, in particular, homelessness, Housing First and Rapid rehousing principles practices.
- Consider the recommendations stemming from recently published reports.
- Understand barriers, share best practice and identify opportunities for continual service improvement.
- Where required agree task and finish groups to address specific issues.
- Produce an informed comprehensive action plan to take forward across the seven Health Board Areas across Wales.

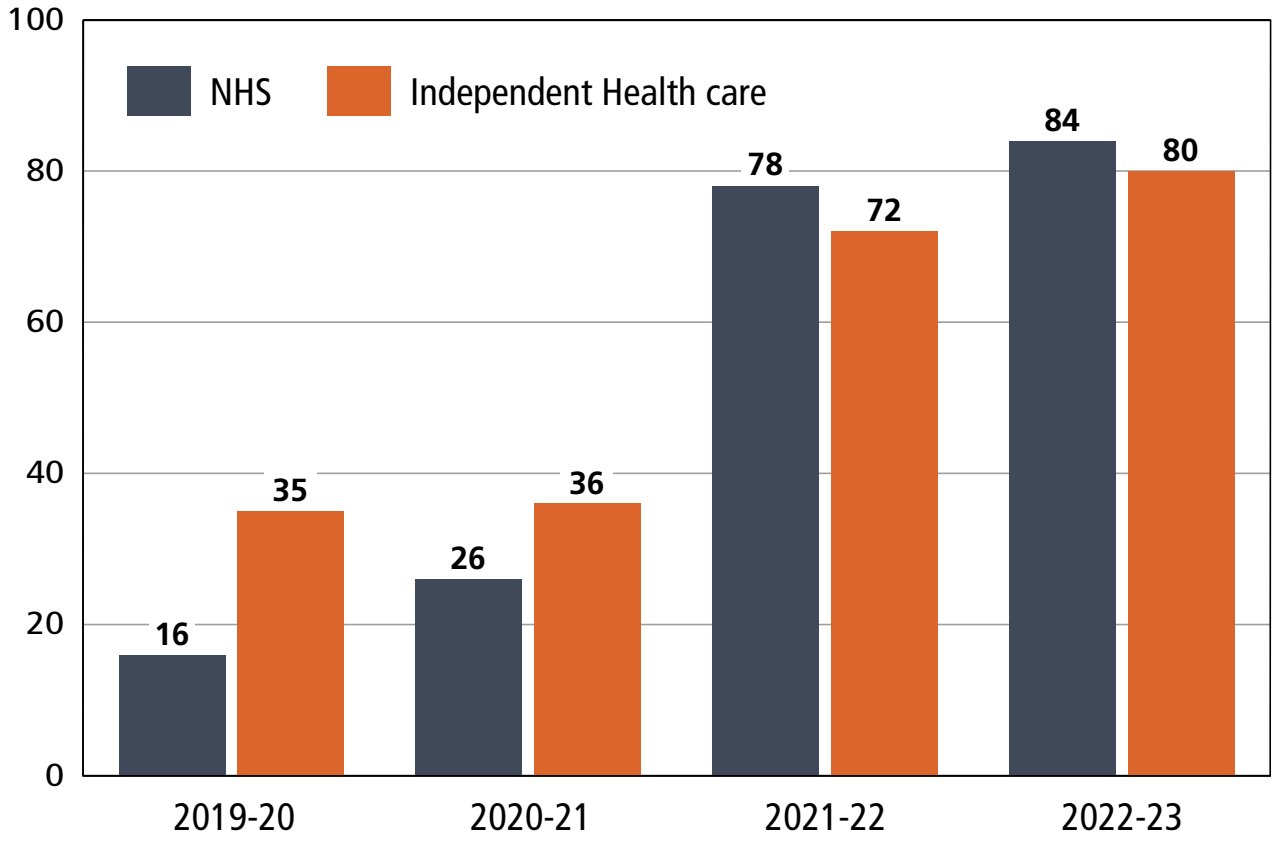
Our National Review of Mental Health Crisis Prevention in the Community published in March 2022 identifies the complexity and challenges of working with individuals who have issues with their mental health and require the support of substance misuse services. The review identified issues of long waiting lists after referral to mental health services, and staff working in substance misuse services raised concerns that referral processes were sometimes overly complicated and inconsistent. In addition, it was recommended that improved co-ordination between substance misuse services and mental health teams was required in some areas of Wales.

4. Listening to concerns

During the reporting period we received:

- 659 complaints and concerns about healthcare providers in Wales.
- 164 of these were about mental health and learning disability healthcare services. This is a 9% increase compared to the previous year. Of these 164:
  - 84 were in relation to NHS mental health and learning disability services.
  - 80 were in relation to independent mental health and learning disability services.

Number of patients contacting HIW with concerns and complaints about mental health care



The following categories are utilised in order to categorise concerns received:

- Access, admission, transfer, discharge (including missing patient).
- Clinical assessment (Including diagnosis, scans, test, assessments).
- Communication.
- Complaints Management.
- Consent and Confidentiality.
- Funding.
- Infection Control Incident.
- Infrastructure (including staff facilities, environment.
- Medical Device/Equipment.
- Medication Management.
- Mental Health Act.
- Other, to capture all concerns that fall outside of existing themes.
- Patient Accident.
- Records Management.
- Safeguarding.
- Self-harming Behaviour.
- Treatment and Procedure.
- Whistleblowing.

The table below shows a breakdown of concern and complaints by their subject – 2022-23.

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	17	7
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	2	2
Communication	7	5
Complaints Management	1	0
Consent & Confidentiality	0	2
Infrastructure (including staff facilities, environment)	8	19
Medication Management	6	2
Mental Health Act	8	3
Other	3	5
Records Management	6	1
Safeguarding	4	9
Self-harming Behaviour	5	3
Treatment/Procedure	7	6
Whistleblowing	10	16
Total	**84**	**80**

The highest category of complaints for the NHS was in relation to:

- Access.
- Admission.
- Transfer.
- Discharge (including missing patient).

Concerns regarding access, admission, transfer, and discharge of mental health patients often revolve around issues of patient rights, informed consent, and compliance with mental health laws and guidance. Patients have the right to timely and appropriate care, and any violations can lead to grievances.

From an NHS viewpoint, managing these aspects of mental health care can be challenging due to the availability of resources, high patient demand, and complex legal and ethical considerations. They may face difficulties in ensuring smooth transitions between care settings and addressing the diverse needs of patients.

From the patient's perspective, concerns can arise when patients experience unfair treatment or feel discriminated against, or lack of communication during the admission, transfer, or discharge process. Many mental health patients already feel vulnerable, so their experiences should be handled with care and empathy.

From an Independent Healthcare Setting perspective, the highest category of concerns received was in relation to infrastructure (including staff facilities, environment).

From the patient's perspective, complaints often emerge when patients experience unfair treatment or feel discriminated against, inadequate treatment, or lack of communication during critical phases of care. These complaints underscore the need for collaborative efforts among healthcare professionals, legal experts, and patient advocates to strike a holistic balance.

Staff concerns

Whistleblowing is different to making a complaint or a grievance. A 'whistleblower' is somebody who makes a 'qualifying disclosure' about a concern at work. HIW is a 'prescribed body' under whistleblowing laws. This means that a whistleblower can make a 'qualifying disclosure' to us and will have certain employment protections under the Employment Rights Act 1996, which was amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA protects the public interest by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern, whether it is a concern about patient safety, safeguarding, financial malpractice, danger, illegality, or other wrongdoing.

Additional information in relation to whistleblowing can be found at our website: www.hiw.org.uk

This year we have seen an increase in the number of whistleblowers raising concerns with HIW compared to last year. Potentially this is due to HIW returning to normal business of undertaking on-site inspections and being more visible following the pandemic. In addition, this may be indicative of the pressures that the healthcare system is experiencing.

- 42 in 2020-21.
- 15 in relation to NHS services.
- 27 in relation to independent services.
- 28 in 2021-22.
- 10 in relation to NHS services.
- 18 in relation to independent services.
- 28 in 2022-23.
- 18 in relation to NHS services.
- 20 in relation to independent services.

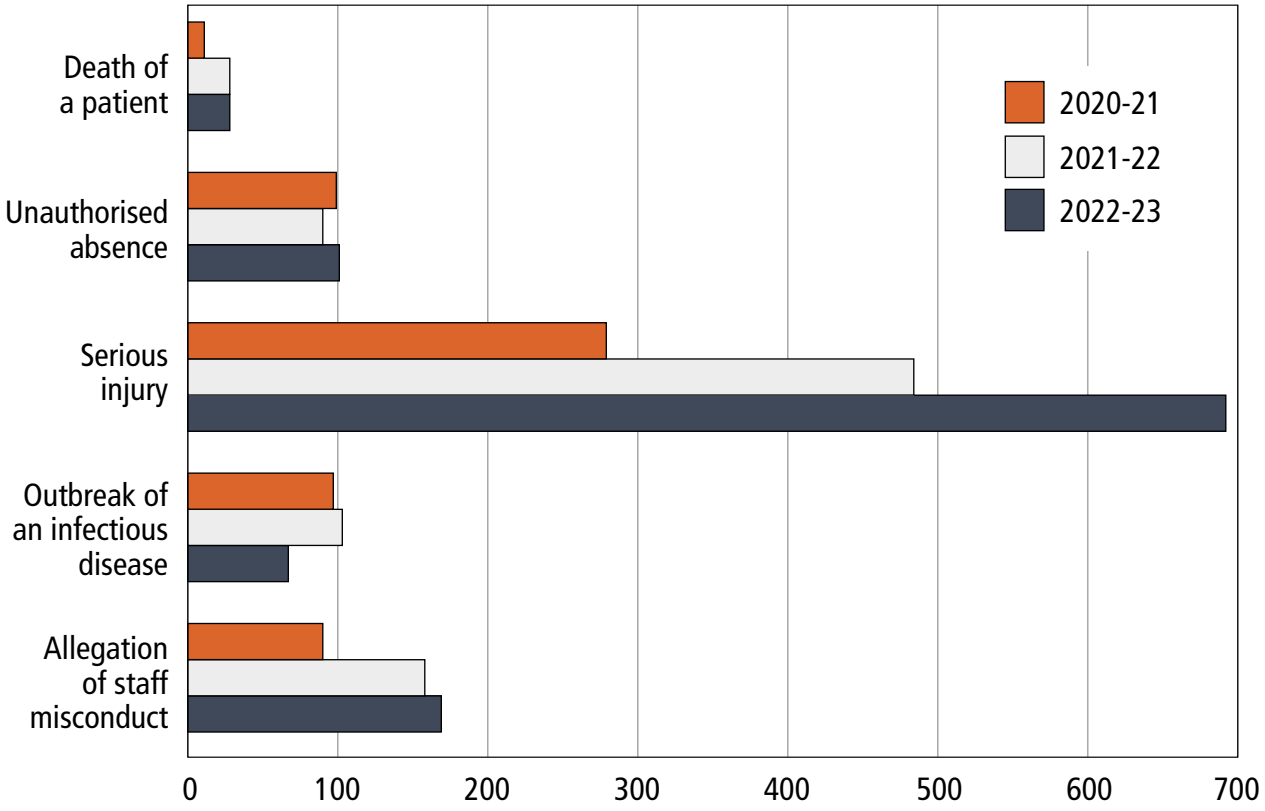
Regulation 30 and 31 Notifications

The registered person of an independent hospital, independent clinic, or independent medical agency is required by Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 to notify us of specific patient safety-related events. This is required by law and includes:

- Death of a patient.
- Unauthorised absence.
- Serious injury.
- Outbreak of infectious disease.
- Alleged staff misconduct.
- Deprivation of liberty.

During the reporting period, we received 902 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was significantly higher than the number of notifications we received in 2021-22. Notifications were themed as shown in chart below.

Regulation 30/31 notifications 2020-21 – 2022-23



The most prominent theme emerging from this year's regulatory notification is the significant increase in the number of notifications in relation to serious injury. We have identified an increase in the numbers of patients self-harming. The range of issues identified within this report, such as a lack of staff, poor risk management plans and care and treatment plans as well as issues with patient observation may be contributory factors in relation to serious injury. In addition, potentially we are seeing this rise as a partial consequence of the COVID-19 pandemic. The extended periods of isolation, economic uncertainties, and heightened anxiety triggered by the pandemic restrictions contributed to a downturn in the mental health and wellbeing of some people. The closure of essential support systems, such as in-person therapy and social networks, left many individuals struggling to cope with their emotional distress. As a result, self-harm emerged as a coping mechanism for some, reflecting the urgent need for accessible mental health resources and a deeper understanding of the pandemic's impact on mental well-being. Additionally, post pandemic, HIW has increased its inspection, assurance and engagement activities which have all enabled an increased awareness of the requirement to complete regulatory notifications in a timely manner.

5. Inspecting mental health and learning disability healthcare services

In 2022-23 we undertook a total of 22 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- CAMHS.

Within the total of 22 we jointly visited three CMHTs with CIW.

During 2022-23 one independent healthcare provider was visited on two occasions because of the nature of the concerns identified.

During our onsite inspections and focussed reviews, we:

- Spoke with a number of patients to ascertain their thoughts on the quality of care and treatment provided.
- Observed how staff from multi-disciplinary teams interacted with patients and each other.
- Examined how the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the role of the Care Coordinators and other members of the multi-disciplinary team.
- We also examined individual patient care and treatment plans, any records of restraints, and any seclusion undertaken.
- Considered if there was an effective discharge pathway in place.
- Examined audit findings and governance processes.
- Considered the diverse range of environments of care, and ensured that risks had been identified and appropriate action taken to mitigate against those risks.
- Reviewed administration of the Mental Health Act and compliance with the Mental Health Code of Practice for Wales (2016).

A list of the health boards and independent registered providers we inspected is included as Appendix A, along with links to the reports of findings.

Our findings

Within this section our findings are broken down into three specific areas, **mental health including older and younger persons and CMHTs, learning disabilities** and **CAMHS**. The findings are drawn from our onsite inspections and focussed reviews we carried out during the year. Where HIW identifies significant issues we send immediate assurance notices for health boards, and non-compliance notices for the independent providers. These notices are sent within 2 days of the inspections being undertaken. The health board/independent provider responds to these notices with an immediate improvement plan that HIW must agree. We issued a total of seven notices between the period 1 April 2022 and the 31 March 2023. This comprised of five for health boards and two for the independent providers.

Findings specific to mental health, including older and younger persons and the CMHTs

A positive finding in the vast majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

Least restrictive care

In October 2022, the Welsh Government published guidance on a framework for reducing restrictive practices in childcare, education, health and social care settings. This framework is intended to promote measures that will lead to the reduction of restrictive practices in hospitals and other settings. Our inspection methodology reflects this guidance, and compliance with the framework is considered within our inspection process.

Some key areas that are considered within our inspections include, planning care in a person-centred way, appropriate language that ensures patients understand the care and treatment being delivered to them, and staff education and development to ensure a skilled workforce in delivering a holistic plan of care in the least restrictive way. However, this must be balanced with a risk-based approach. Our inspections aim to ensure that blanket restrictions for patients are not being used and where restrictions are necessary, they are individualised and based on a person's risk areas.

However, we did find examples where we were not assured that the least form of restrictive practice was being used. More specific details will be identified in the restraint section.

Use of restraint

Any form of restraint, whether it is physical, chemical, environmental, or mechanical, should always be a last resort when all other interventions have failed and not had a successful outcome for the patient. All forms of restraint must have a detailed plan of care describing how the restraint can be avoided by staff, understanding any triggers that may necessitate that level of intervention taking place. The Mental Health Act 1983 – Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. The Code is very clear that restraint must only be used as a last resort. In terms of mechanical restraint, the Code stipulates that HIW must be consulted if this is being considered. The use of mechanical restraint in hospitals is very rare but in the event it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patients' extreme challenging behaviour, whether that is violence directed at others or self-injury. This form of restraint, as with all restraints, must be regularly reviewed and be in place for the shortest possible period of time.

During our visits, where restraint is being used, we routinely examine patient records and consider a number of factors including:

- The position of the patient.
- Length of time the patient was restrained for.
- Number of staff involved and that they are suitably trained.
- Triggers that led to the point where a restraint was initiated.
- Ensuring that all restraints are routinely examined any if there is any learning from the restraint.

- Debriefs on the restraint are held for all staff involved.
- Any lessons learnt that need to be considered during the restraint.
- Any restraint undertaken is thoroughly documented.
- A robust governance process of all restraints including analysis of each restraint undertaken.

Generally, restraints were well documented, and systems were in place to monitor any incidents of restraint. However, during one inspection we identified that the 'Use of Restrictive Physical Intervention' policy required a review, as a matter of urgency, to provide clear guidance to staff. In another visit we identified that the health board had not ensured that the Physical Restraint Policy had been reviewed to provide clear guidance to staff. Up to date policies are an essential component to ensure that the latest guidance is being utilised to safeguard patients and staff.

In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because a well trained workforce can help reduce the incidents of patients and staff being injured during a restraint. In addition, we identified on one of our inspections that a health board did not ensure that restraints are recorded in patient records and that patient's notes are updated.

Use of seclusion

The Mental Health Act 1983 – Code of Practice for Wales 2016 has a section dedicated to the use of seclusion. Seclusion is described within the Code as "the supervised confinement of a patient in a room which may be locked". It is interesting to note that the Code uses the term "may be locked", implying that it is possible for a patient to be secluded within a room behind a door that is closed but not locked. The Code also sets out timeframes for when continued seclusion should be reviewed, these are, "every two hours by two nurses" and "every four hours by a doctor, or a suitably qualified approved clinician". The Code also states that seclusion is used as a last resort and for the shortest possible time. Policies and procedures must be in place for the use of seclusion and should reflect NICE and other guidelines.

It was pleasing to note that no issues relating to seclusion were identified during our inspections throughout 2022-23. However, we did identify, during one of our visits, that there was no structured policy regarding use of the Extra Care Area (ECA) on both wards. We recommended improvement in the documentation and daily records entries for patients who spend time in the ECAs so that a clear picture of their time spent on the ECA can be established. It must be noted that ECAs are not seclusion suites.

Section 136 Suites

Section 136 Suites are designated facilities that an individual is taken to by a police officer if they believe it is required in the interests of that person or for the protection of others. The removal of the person is only permitted in a place to which the public have access.

Within our inspections we visited one section 136 suite located within a hospital. During that visit we only identified one issue for the Health Board and that was the provision of appropriate observation mirrors to enable staff to see concealed areas in the section 136 suite.

Patient Observations

Patients who are in an acute and/or challenging phase of their illness will require a degree of effective observational levels to ensure that their safety and the safety of others is protected. The term enhanced levels of observations can range anywhere from 15 minutes to more intense levels of 1 to 1, 2 to 1 and so on.

During our inspections, we consider the appropriateness of the levels of observations, whether there are sufficient staff to undertake the levels, that a robust care plan and risk assessment is in place, and whether there is a regular review of the effectiveness of these observations. Generally, we observed that patient observations were undertaken appropriately, regularly reviewed and staff understood the importance of effective patient observations.

In some hospitals, we identified a range of significant issues, including, a lack of a review of a Therapeutic Observations Policy which had expired in December 2021. Another example was that observational charts were not completed accurately.

In addition, we found two examples where the observational policy had not been reviewed and updated in line with the timescales identified. We also found issues, on one inspection, with documentation of patient observations including observation records that contained many significant gaps during which they were not updated for extended periods of time. We also saw an example of one record which had not been updated for over six hours and another left entirely blank. Because staff had failed to update patient therapeutic observation records to reflect that they had been conducted, we could not be assured that patients were being monitored and fully protected and safeguarded on the ward.

Meaningful and therapeutic activities

A key part of our inspection process is to examine the range of meaningful therapeutic, social and recreational activity available to patients. Meaningful activity can promote and have a very positive impact on patient wellbeing and their recovery pathway.

In most of our inspections, we found a number of good examples of patients being actively engaged with a range of therapies that they commented positively upon. This is a significant improvement on our previous years of inspection findings where we identified a number of issues with provision of meaningful activities. Only in one inspection did we identify issues of a health board that was not providing a wide range of therapeutic and physical activities for patients on the ward, including activities outside of weekday working hours and opportunities to exercise. This issue was also identified in a previous recommendation, following an inspection of the ward in 2017.

We continued to identify issues with section 17 leave under the Mental Health Act, but these will be addressed within section 6, Monitoring the Mental Health Act, of this report.

Medication Management

The safe and effective administration, storage and ordering of medication is an area that our inspection process routinely focuses upon. This section of the report addresses the inspection findings from 15 hospitals and 3 CMHTs. Disappointingly we identified issues in 14 of the 18 visits. This is an area where HIW has previously identified significant issues and it is disappointing that the health boards and independent providers do not have robust systems of audit and governance to address these issues. Issues identified covered many different aspects of medicines management with the most significant being:

- Full sharp boxes not being appropriately disposed of.
- Medication not always stored securely inside the clinic room and being left unattended on the wards.
- Controlled drugs were sometimes not administered correctly and the frequency of stock checks was not aligned with health board policy.
- Medication Administration Records (MAR) not completed correctly.
- Medication trolleys were left unattended and not locked and secure when not in use.
- No system in place to audit medication charts.
- A lack of Consent to Treatments forms attached to MAR charts and regularly reviewed.
- Outdated medicines not always securely stored away from general stocks and arrangements for their timely collection and disposal was not always in place.

The issues listed above demonstrate a range of diverse findings that fail to give HIW a level of assurance that medicine management systems are robust and ensure the necessary checks and audits are in place to ensure patient safety. This has been a reoccurring theme for the past years and health boards and independent providers must strive to do better in this area.

Patient information

A range of useful and explanatory information that is in a suitable format is essential to inform patients about key areas for their stay in hospital. This information can reduce the risk of any misunderstanding in relation to care and treatment processes that patients can expect during their stay in hospital and/or input from CMHTs.

In some of our inspections we identified issues in relation to the lack of availability of patient/visitor information on display in the following areas:

- Information on making a complaint.
- Advocacy services.
- The NHS Putting Things Right.
- Guidance around mental health legislation.
- Health promotion including healthy eating and well being.
- Healthcare Inspectorate Wales.

In addition, patient information was not always provided in an accessible format for patients with communication difficulties or cognitive impairments.

Risk assessment and care planning

A comprehensive approach to risk management and care planning is essential to ensure patients have a robust plan in place to address any risks identified. In terms of care and treatment plans, HIW has a specific responsibility in monitoring part 2 of the Mental Health (Wales) Measure 2010. Part 2 of the Measure requires all patients receiving secondary mental health care to have a care and treatment plan in place. Care and treatment plans should be comprehensive, holistic, and patient focused.

These plans under the Measure cover a number of distinct domains including:

- Finance and money.
- Accommodation.
- Personal care and physical well-being.
- Education and training.
- Work and occupation.
- Parenting or caring relationships.
- Social, cultural, or spiritual.
- Medical and other forms of treatment including psychological interventions.

Care and treatment plans are overseen by Care Coordinators who ensure the timely review of these plans so that they continue to address the key needs of the individual within the domains listed above. In addition to the Measure, there must also be a robust risk assessment process in place that takes account of historical and present risks. Any risks identified must have a robust plan of care in place to mitigate against identified risks and strategies in place to manage these.

Care Coordinators are key individuals, and their input is central to assisting the patient with their journey through secondary mental health services. This is another area that is assessed within our inspections.

During our inspections we consider the role of the Care Coordinators and examine the care and treatment plan documentation. We also interview patients and staff to get an understanding of the effectiveness of the care and treatment plan. We have again this year identified some examples of good practice including, patient care plans being regularly reviewed by staff and updated to reflect current needs and risks and suitable protocols being in place to manage risk, health and safety and infection control. In addition, written evaluations completed by the care staff were found to be comprehensive and reflective of the care provided. Patients were involved in the planning and provision of their own care, as far as possible, and where patients were unable to make decisions for themselves, we saw evidence that relatives were consulted. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- The Malnutrition Universal Screening Tool was not completed and regularly reviewed for all patients; this is essential for identifying all patients who may be nutritionally compromised so early dietary intervention can take place.
- A lack of patients' physical conditions, and required interventions, detailed in care plans.
- Care and treatment plans were not always fully completed, kept up to date and completed in accordance with the Mental Health (Wales) Measure 2010.

- HIW was not assured that all aspects of care are being delivered in a safe and effective manner. For example, in one patient's record we reviewed, the Speech and Language Therapist (SALT) directed staff to implement a puree level 4 diet. The patient's records documented that they were at risk from aspiration and choking if they ingested a normal diet. It is evidenced in the notes post the advice from the SALT that the patient had been given a level 7 diet, contrary to the SALT advice, therefore placing the patient at risk of significant harm.
- Concerns around management of risk were raised following a review of patient records. These highlighted that documentation was not regularly updated, fully completed, specifically suicide risk sections were incomplete or very brief information recorded that lacked specific detail. As a result, we were not assured that the current controls or mitigating actions put in place were effective.
- Patient records were left unattended.
- No evidence of pain assessments being completed in patient records and WARRN risk assessments were not completed and updated in conjunction with the care and treatment plans.
- A lack of detailed information was recorded within the care and treatment plans to reflect patient needs and reasons for interventions in order to ensure safe patient care.

The issues identified above are wide ranging covering a number of different areas of risk and care and treatment documentation. Effective risk, and care and treatment plans, are an essential part of the care delivery for patients and health boards and independent providers must do more to ensure a robust audit and resulting action plan to address deficits in this key documentation. In every health board hospital and the CMHT inspections, 11 in total, we identified issues in relation to risk and care and treatment plans. In the independent sector we identified issues in four of the seven inspections undertaken.

In relation to care and treatment plans, we required immediate assurance in one of our inspections undertaken in the health boards. This resulted in the health board providing an immediate improvement plan.

Environment of care

During our inspections we routinely undertake a tour of the wards. This enables us to identify issues and make observations in relation to the appropriateness and safety of the environment for the care and treatment of the patient group.

In five out of eight health board hospitals, that we inspected, we identified a lack of audits and the management of environmental ligature risks. In addition, on one of these visits we identified an issue that required an immediate assurance where HIW was not assured that ligature risks had been rectified. We had identified concerns which could result in significant patient harm in a HIW quality check in 2020 and this has still not been addressed.

We also identified, on some visits, the lack of availability and appropriate storage of ligature cutters.

Other environmental issues identified included, the requirement for redecoration and refurbishment of ward areas, broken furniture, stained and marked carpeting, inaccessible garden areas due to a lack of maintenance, damaged door handles and grab rails, and faulty ceiling lights.

In addition, a number of environmental issues identified were impacting upon patients' privacy and dignity, and included the lack of blinds or curtains for patient bedrooms and a lack of appropriate privacy doors on patient bathrooms.

Workforce

There are significant healthcare workforce challenges across Wales. Recruiting and retaining sufficient, knowledgeable and well-trained staff is very difficult and is creating challenges for both health boards and independent providers in sustaining services. Well trained, knowledgeable staff in sufficient numbers is key to ensuring patients receive the professional time that an effective care pathway requires. Feedback from patients in most of our inspections was very positive towards staff and many patients appreciated the pressure that workforce shortages was creating. Our staff and reviewers observed many positive interactions by a very busy workforce under pressure.

Workforce issues were identified in 13 out of 18 inspections across a range of disciplines and some of these are outlined below:

- Patients' physical healthcare problems were not assessed in a timely manner.
- High level of agency staff usage and a lack of focus on the recruitment of staff into permanent vacancies on some of our visits.
- A lack of professionals on-site including, occupational therapists, psychologists, physiotherapists, and activities coordinators.
- In some of our inspections we identified a lack of review of staffing levels to ensure that they meet the demands of the patient group. Health boards must ensure that substantive medical staff are appointed as far as possible to ensure continuity of care.
- One-to-one psychology waiting times were very long and the health board/ local authority must consider how these times can be reduced to ensure that patients receive the most appropriate level of intervention.
- A health board and local authority must review the duty arrangements in order to ensure that staff are able to fully meet the demands of their substantive roles.
- Enough female staff was not available for enhanced observations in bedroom areas.
- An independent provider did not ensure that a comprehensive and robust risk assessment process had been undertaken regarding nurse staffing requirements.
- An independent provider did not ensure all recruitment follows the open and fair process set out in the safer recruitment and selection policy.

It is evident, from the range of issues identified above, that significant workforce challenges were having a detrimental effect on the care pathway for patients. In addition, workforce challenges were not confined to one discipline of staff, but shortages were identified across all disciplines. All health boards and independent providers must ensure that they have a short and longer-term strategies to address these shortages and that the strategy is regularly reviewed for its effectiveness of both recruitment and retention of a sufficient number of knowledgeable and skilled staff. Where agency and bank staff are used, it is desirable for the same members of staff to be used as opposed to different staff for each shift.

In relation to section 17 and patient leave under the Mental Health Act this area will be further analysed in section 6 of this report.

Governance

Robust governance and audit processes are key to identifying, at an early stage, where the delivery of a service needs to improve to meet the needs of the patient group more effectively. Unfortunately, many of the issues identified within this section of the report may not have been prevalent if effective audit and governance processes were in place. Audits are key tools to drive improvement and ensure that services meet the needs of vulnerable patients. In addition, when things go wrong, it is vital that lessons are learnt to prevent issues reoccurring. This cycle of continuous improvement ensures a sound and proactive governance framework that achieves more positive outcomes for the patient group. Unfortunately, in 9 out of 18 (50%) of our visits, we identified issues in relation to audit and governance. Some of the areas include:

- A lack of audit/governance for policies; some had not been reviewed within the identified timescales in some cases this was in excess of over a year.
- In one visit, we observed issues with the roles and responsibilities of the Acute Care Clinical Site Manager and a lack of time to ensure that they are able to discharge their duties effectively across all the services that they are responsible for.
- Failure to implement a robust governance program of audit to ensure that access cards issued by the hospital are monitored and accounted for to prevent security breaches and ensure the safety of patients, staff and visitors.
- A health board did not implement a programme of governance oversight in respect of the medicines management system, to ensure that daily checks, areas of non-compliance and areas requiring improvement are identified and addressed appropriately.
- A lack of recording of mandatory training on one system for ease of governance and monitoring.
- A lack of staff awareness of the importance and relevance of audits, and a lack of participation so that they can better understand and improve audit outcomes.
- Audit activities were not reviewed to ensure that they were being completed appropriately and were effective in identifying errors and areas for improvement.
- An independent provider did not have effective and proactive governance arrangements in place to check compliance with relevant regulations and best practice standards to focus on continuous improvement within the service.

In addition, there was a lack of assurance that a health board had a robust governance framework in place, e.g. during the inspection it was difficult to locate and access patient information. Attempting to follow the care and treatment of an individual was complex and time consuming across the individual sources. This would be of particular concern for an agency member of staff attending the ward for the first time where it would be very difficult for them to understand patient behaviours and the appropriate actions to take to manage them. We also identified that no formal minutes were being routinely recorded for patient related meetings, weekly ward rounds, and for MDT meetings. This demonstrates a weakness in the governance processes in place for maintaining patient safety. These areas resulted in us issuing an immediate improvement notice to the health board.

Findings specific to Learning Disabilities

During 2022-23 we undertook three inspections of learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and treated patients with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group.

During one of our three visits we required immediate assurance for a number of significant issues as described below.

We could not be assured that the health, safety and welfare of patients, staff and visitors at the unit was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored, and where possible, reduced or prevented. The following issues required immediate action by the health board:

- We saw three examples of immediate potential risk to patient safety and advised staff to take action, but only one risk was removed prior to the conclusion of our inspection.
- We reviewed four records of patients who were undergoing therapeutic observations and found that the therapeutic observation records contained many significant gaps during which they were not updated for extended periods of time.
- We reviewed six Datix incidents relating to medication errors and patient restraint incidents, and found there was no investigation update within all six incidents. Senior staff confirmed that they did not understand the correct procedure to follow in order to successfully manage and investigate Datix incidents in accordance with their duties.
- Staff compliance with Positive Behaviour Management (PBM) and Breakaway Training was 79%. Staff were unable to provide HIW with accurate restrictive practices data to determine the number of patient restraints which had occurred within the past three months. Staff could not identify whether members of staff who were not compliant with their restraint training had participated in patient restraints during this period.

Staff and patient safety

Patients and staff feeling safe, and having systems and processes in place to protect their safety, is key to achieving positive outcomes for patients and staff having confidence in working within a safe environment.

In terms of staff safety, on one of our inspections we identified a lack of access to personal safety alarms, or a policy in place around the use of safety alarms. In another inspection the health board did not provide an effective and appropriate alarm system on the ward to ensure that staff, patients and visitors are able to raise alarms when necessary. Other issues identified included gaps in information being provided to staff when a patient is admitted and COSHH equipment not always being stored correctly. Also, we identified that senior managers did not consider the limitations of the environment and the clinical opinion of MDT when making decisions regarding patient admissions.

Lastly, oxygen cylinders were not appropriately secured to protect the safety of patients, staff, and visitors.

Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. Issues identified, include, a lack of pharmaceutical support to improve medication management, special instructions relating to patient medication not being recorded in patient medication records to ensure that all staff are aware of the correct procedure to follow. Also, regular pharmacy audits were not undertaken on one ward and there was a lack of pharmaceutical support to improve medication management on two wards. In addition, on some of our inspections there were no photographs of patients attached to MAR charts to assist with patient identification.

Training

A trained, skilled, and knowledgeable workforce is essential to achieving positive outcomes for patients. During our visits we identified a number of areas of concern, and these included low numbers of staff training for DoLS and low compliance with mandatory training. In one of our inspections one of the health boards had not reviewed and considered any additional training courses which would develop staff and benefit patients on the ward. Value-based training, for all staff, should be considered to ensure that appropriate language is used in relation to patient care; so that patients are actively listened to, acknowledged, and respected on the unit.

Lastly, on one of our inspections, we identified that staff training and monitoring systems, should be reviewed to ensure that current and accurate training compliance figures can be retrieved, for the effective management of staff training levels and the safety of patients and staff.

Case study for DoLS

On reviewing the care notes for one individual we identified a range of issues in relation to DoLS.

We found that the statutory authorisation paperwork was missing from the patient file. However, when we highlighted this issue to staff, they later produced the authorisation document, but there were significant errors within the form. The form wrongly cited an alternative health board as the supervisory body. The urgent authorisation was authorised for a seven-day period in October 2022, after which it expired, but there was no further DoLS authorisation documentation on file. We discussed this matter directly with the health board's DoLS team, who advised that the incorrectly completed form initially submitted to them by unit was rejected and returned to the unit to be rectified and resubmitted. During the inspection the DoLS

team advised that the unit had never returned the correct documentation to request a further extension of the patient's DoLS authorisation which meant the DoLS authorisation had expired. Following the inspection, we were later advised that the documentation had been amended correctly and sent to the DoLS team therefore authorisation had not expired. We discussed these issues with staff and noted that staff compliance with nonmandatory Mental Capacity Act training was 63 per cent. We were advised that additional Mental Health Act training will be arranged for staff. We recommend that unit staff should be provided with additional training, instruction, and governance with regards to the MHA and DoLS to ensure compliance with legislation and that documents are completed and submitted correctly.

Patient activities

During one of our visits, we identified that an activity timetable should be kept up to date and made available to patients and the activity room should be decluttered and converted into a protected activity room for patients. In addition, on the same visit, a full time Occupational Therapist (OT) needed to be recruited to assist in the development of a comprehensive therapeutic activity programme.

Care plans and risk assessments

A patient's care plan must reflect all assessed needs, and have any risks clearly identified and a strategy in place to deal with those risks. Our visits found that patient care plans and individual risk assessments were not always updated to include additional information about how individuals are supported in bathroom and toilet areas so that patients and staff are safeguarded when administering personal care. Also, patient care plans were not always updated to include the frequency of inspection and repair of patient items which are regularly damaged.

In one of our inspections the health board needed to review its processes for transferring relevant information with patients who are transferred to hospital to ensure that sufficient information is retained on the ward to allow for effective communication and MDT review.

There were also issues with a health board needing to review the current health record system with a view to implementing an electronic health record system in future and to support the care and treatment plans. In addition, pen profiles should be attached to patient files for the awareness of staff, particularly agency staff who are not familiar with patients.

Lastly, we identified that a unit was not adhering to the Division of Mental Health and Learning Disabilities Principles for the Management of Mixed Sex Wards, and that safeguarding measures needed to be put in place, and care plans and risk assessments updated accordingly.

Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. This principle is important to all aspects of care and treatment.

In relation to food and drink patients should be able to view a pictorial and written menu to assist their choices, however, on one of our visits this was not happening.

Governance

A range of governance issues were identified during our visits. These included:

- A lack of access to governance and audit documents in the absence of ward managers.
- Policies not being reviewed before they expire, resulting in staff not being supported in their roles.

- Training compliance was not clear for ease of governance and monitoring.
- The lack of an audit process to ensure all visitors to the unit are recorded and accounted for.
- A lack of understanding, by some senior staff, on their roles and responsibilities in respect to audit governance.
- A lack of review, by senior management, for clinical audits so that any issues are identified and any opportunities for quality improvement are shared.

Findings specific to CAMHS

During 2022-23 we inspected one of the three in-patient CAMHS units in Wales. We identified a number of positive findings which included positive feedback from young people about the care they received at the hospital and about their interactions with staff. The young people also felt that they could engage and provide feedback to staff on the provision of care at the hospital in several ways. A mental health advocate was also available to the young people to provide them with support and information. However, our inspection also identified a range of issues. In relation to care and treatment plans, risk and other assessments, physical health assessments undertaken were not tailored to the individual but followed a generic template, and care and treatment plans did not indicate whether each young person should keep their NG tube in situ or whether it is removed after feeding. We ask the service to ensure that the justification for NG feeds is recorded for each young person that it is deemed appropriate for. Care and treatment plans were not always created for identified needs and the service must review the existing care and treatment plans, in place for each young person, and assess whether there are any missing care and identify treatment plans that need to be created.

In relation to restrictive practices the service provided insufficient assurance on their strategy for reducing the number of restraints at the hospital in line with the Reducing Restrictive Practice Framework for Wales. In relation to effective governance the service was required to improve the quality of incident reporting and to improve communication to staff on the outcome of any safeguarding incidents that they have been involved in or raised. Also, the service must ensure there is clearer responsibility in relation to ownership and sign off of any safeguarding concerns that have been raised.

Other issues identified included, a lack of therapeutic activities taking place as scheduled and the service needing to improve its communication to family members and carers of the young people at the hospital in relation to their care and wellbeing (where contact is appropriate). Also, in relation to visiting, the service was required to review its visiting arrangements, including frequency of visits, to ensure they meet the needs of the young people and family members and carers. In terms of training, there were staff, including agency staff, undertaking observations on young people that had not completed their training in therapeutic observations. We also observed a lack of engagement with the young people, from staff undertaking observations, to help best support them while undertaking therapeutic observations.

Lastly, in terms of the environment of care, the service needed to improve the process for identifying and removing blood stains following incidents in a timelier manner and cleaning schedules must be maintained as expected.

6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the Mental Health Act 1983.

The Mental Health Act is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The Mental Health Act provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the Mental Health Act. Other individuals and organisations include, officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under The Act. This section of the annual report details how the Mental Health Act is being implemented and how the powers granted are being exercised and monitored in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2022-23 we focused on a number of key areas including:

- Are patients lawfully detained and is the care and treatment appropriate.
- Are patients informed about their rights, at the point of detention, and then at regular intervals. Is it clear if patients understand the significance of their detention or not.
- Does the treatment consider the patient's wishes and do they feel as if they are treated with dignity and respect.

We measure the above areas by talking to detained patients, their relatives, any advocates (if present) and any representatives of the patient if they so wish. We also speak with staff including Mental Health Act administrators and other key individuals. In addition, we examine Mental Health Act detention papers to ensure patients are lawfully detained and the Mental Health Act 1983 Code of Practice for Wales 2016 is taken into consideration. Finally, we consider the robustness of the audit and governance processes in place.

Mental Health Act Reviewers

Mental Health Act Reviewers were involved in all our inspections and their primary focus is determining whether the Mental Health Act was being lawfully applied and the Mental Health Act 1983 Code of Practice was being adhered too. Within the inspection, detention and care and treatment documentation is examined to ensure compliance with the Act. The reviewers focus upon a number of key sections of the Act including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. A patient's understanding is also considered and any leaflets, about their right, are provided in a suitable format and languages to assist understanding. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

Our Findings

Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity of each patient had been assessed and clearly documented. Although not part of the Mental Health Act, a good standard of mental capacity assessments was being undertaken as required, when DoLS referrals were made. There was good evidence of Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocacy involvement in patient case work.

However, on some of our visits, we identified that patients records needed clarification and explanation regarding IMCA input when there is no family or lasting power of attorney. The health board must ensure that patient records reflect IMCA input when no lasting power of attorney or family involvement.

In one case, whilst capacity assessments for consenting to treatment were completed upon admission, these should preferably be recorded on an appropriate proforma to ensure a consistent and standardised approach to assessing mental capacity in the decision making process for treatment.

Lawful detention/treatment

A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. The detention paperwork we examined had commenced and been renewed within the requirements of the Act. In addition, the records we viewed were generally well organised, easy to navigate and contained detailed and relevant information.

During one of our visits, we identified that a number of consent to treatment certificates had expired, meaning that there was no authority to give medication. In addition, on one of our visits, we found no evidence of Section 62 being recorded in patients notes for those that had expired. We recommended that the health board review its Section 62 forms and ensure

that the forms are received by the mental health team before the end of the working day so that all certificates are up to date and the correct entries documented for medication to be authorised.

In addition, patients' legal status was not always recorded on medicine administration records and errors in Mental Health Act records were not signed and dated appropriately. Other issues identified, included, a lack of copies of detention papers kept with patient records and a lack of consent to treatment certificates kept with patient's drug charts.

Mental Health Review Tribunal for Wales (MHRT)

We noted that Mental Health Act Tribunal and Review Panels generally took place in a timely manner, although we were informed, on one of our inspections, that there were difficulties recruiting and retaining panel members during the pandemic. We were assured that there are efforts underway to recruit additional panel members to ensure that timely reviews take place.

Section 17 leave

Section 17 leave was one of the areas where we identified the greatest number of issues during our visits. The issues identified included:

- Section 17 leave forms were not signed by the patients and that patients were not offered a copy.
- Photographs of detained patients undertaking Section 17 Leave were not kept on record.
- Section 17 leave forms were not fully completed.
- Section 17 leave forms did not have a space for patients to sign, and if a patient lacked capacity to consent this was not recorded.
- A lack of patient involvement in the section 17 leave process.

Ensuring patients' rights

Section 132 and 132A of the Act places a duty upon hospital manager to ensure detained patients understand how the Mental Health Act applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

During our inspections we identified, on occasions, that there was no record of ongoing provision of rights as directed by the Mental Health Act Code of Practice for Wales. In addition, on one of our inspections we noted that one patient had not had their rights read to them since March 2022 and the inspection was undertaken in July 2022. Detained patients must have their rights read to them as required by the MHA.

Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

Statutory consultees must know the patient well enough to undertake the role. During the discussion with the SOAD, they should consider commenting on the proposed treatment, the patient's ability to consent to that treatment, the views and wishes of the patient, any other possible treatment options, and the facts of the case.

During one of our inspections, we found, in two patient records, that there was evidence that the Second Opinion Approved Doctor had consulted with the two statutory consultees, however, there was no record of their views and agreement. In addition, there was no associated proforma available for the statutory consultees to record their views and sign and date their conclusions.

Community Treatment Orders (CTOs)

Within our CMHT inspections we considered how the Mental Health Act was implemented for patients within the community. Within the 2 inspections we undertook of health board CMHTs we identified the issues below;

To fully strengthen compliance with the Act, one of the health boards was asked to ensure that the following information is recorded in CTO documentation:

- Reasons for the conditions.
- A record that the conditions (and reasons) have been explained to the service user.
- The conditions have been explained to other concerned parties.
- Approved mental health professional (AMHP) views on the CTO are recorded.

To ensure compliance with the Mental Health Act, another health board was asked to ensure the following:

- That the appropriate Consent to Treatment (CTT) certificates are used, and that copies of the certificates are kept with medication administration charts.
- That capacity assessments are undertaken as part of the CTT process.
- That changes in medication are reflected in CTT certificates.
- That patients' rights are regularly reviewed.

Other issues included:

- A lack of Section 12 doctors.
- A lack of copies of the Mental Health Act 1983 Code of Practice for Wales (2016) available on some of the units.

Audit and governance arrangements

Part of our scrutiny of how services discharge their powers and duties in relation to the Mental Health Act 1983 is to consider the audit and governance processes. During our visits we reviewed the systems and processes that mental healthcare providers had in place to ensure oversight, monitoring and audit of their application of the Act. A number of issues were identified in some of our inspections, including the absence of an audit process in respect of consent to treatment forms and no regular audit activity of the records to ensure that records are well maintained, fully completed and easy to navigate.

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (SOAD) is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

In 2022-23 the SOAD service operated as a hybrid service. Our methodology specified that all SOAD visits should occur in person for the purposes of interviewing the patient. Consultations with Statutory Consultees could, however, still be undertaken remotely.

Due to capacity and operational availability of SOADs, the option for remote certification is still utilised to ensure a timely and prompt certification is provided, which we believe is in the best interests of the patient. All patients, however, are still offered an interview via teams/ or telephone consultation in cases where remote certification is utilised.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their Certification (CO) forms.

Full advice on our methodology is available on our website: www.hiw.org.uk

SOAD Recruitment

We have advertised the vacant Lead SOAD and Deputy Lead SOAD and anticipate the posts to be filled in the summer of 2023. The creation of a Deputy Lead SOAD as a new post is intended to provide further resilience to the service. We have also recruited three new SOADs to further bolster the resilience and effectiveness of the service, and these new SOADs will be in post by the Summer of 2023. This brings our total to 15 active SOADs operating in Wales.

SOAD training

We provide a regular annual training programme to all of our SOADs to ensure best practice and continuous improvement in their role. In 2022-3, however, due to unforeseen circumstances, we were unable to provide an official training programme. This has been highlighted as a priority for our new Lead SOAD on appointment, and we will then proceed to make arrangements for training sessions to resume in the Autumn of 2023.

SOAD activity

During the period April 2022 to March 2023, the RSMH received 694 requests for a visit by a SOAD. This figure is a decrease from the April 2021 to March 2022 requests.

These figures can be broken down as follows:

- 640 requests related to the certification of medication.
- 42 requests related to the certification of ECT.
- 12 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

Requests for visits by a SOAD, 2006-07 to 2022-23[1]

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690

1 Source: SOAD requests to HIW

Year	Medication	ECT	Medication & ECT	Total
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694

Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

- 2 working days for a referral in relation to ECT.
- 5 working days for referrals about prescribed medication when the patient is in hospital.
- 10 working days when the referral is in relation to someone subject to a Community Treatment Order.

Whilst we strive to meet the above timescales, there are a number of reasons why sometimes the timescales are not met. Some of these reasons include the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. As reported last year, improvements within the timeliness of the service have been maintained since the introduction of telephone and email consultations with the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

Throughout the pandemic we have continued to work with the Mental Health Act Administrators in local health boards and independent mental healthcare settings, to ensure that the SOAD referral and assessment process was completed in a timely way.

We have retained a hybrid methodology of remote and on-site visits following the implementation of the COVID-19 safe methodology. This is to maintain the improvements in the referral and assessment timescales seen during the reporting period. This includes, offering the option of telephone or video conference consultations with the Responsible Clinician and Statutory Consultees, and maintaining the requirement for health boards and independent mental health hospitals to provide information for the SOAD in advance.

However, our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the Mental Health Act Administrators (MHAA) for all settings to try and ensure improvements in this process next year.

Our guidance to all SOADs is that they should record the method of consultation with the patient on their CO forms under the reasons section.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW.

The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year, HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are usually reviewed on a monthly basis by our lead SOAD for Wales.

Due to unforeseen circumstances beyond our control, there was a significant impact on this service in this reporting period due to the vacant Lead SOAD post. We appointed an interim Lead SOAD with assistance from Care Quality Commission (CQC) to assist in reviewing treatment whilst we advertised our vacant Lead SOAD post.

As reported last year, there remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

There continue to be instances where an additional medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

Further to the appointment of a new Lead SOAD we will look to improve our reporting mechanisms in future reports.

8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities and inspection of mental healthcare services and services for people with learning disability and autism.

We also analysed concerns raised with us by patients, relatives, staff, and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Appendix A

Relevant work 2022-23

	Hospital	Link	Date	Type
	Health Boards			
1	Bryngofal Ward, Prince Philip Hospital, Hywel Dda University Board		11-13 July 2022	Inspection
2	Ty Cyfannol and Annwylfan Wards, Ysbyty Ystrad Fawr Hospital, Aneurin Bevan University Health Board		5-7 September 2022	Inspection
3	Bryn Hesketh, Betsi Cadwaladr University Health Board		1-2 November 2022	Inspection
4	Hydref and Gwanwyn Wards, Heddfan Psychiatric Unit, Betsi Cadwaladr University Health Board		7-9 November 2022	Inspection
5	Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board		14-16 November 2022	Inspection
6	Pine and Ash Wards, Hafan y Coed Mental Health Unit, University Hospital Llandough, Cardiff and Vale University Health Board		9-11 January 2023	Inspection
7	Learning Disability service Swansea Bay University Health Board NHS Hospital Setting – on behalf of Cwm Taf		24-25 January 2023	Inspection
8	Learning Disability service Aneurin Bevan University Health Board NHS Hospital Setting		31 January – 1 February 2023	Inspection
9	Tawe Ward / Ystradgynlais Community Hospital Powys University Health Board		9-11 January 2023	Inspection

	Hospital	Link	Date	Type
10	Ward 12 & Ward 16, Mental Health Services for Older Persons, Llandough Hospital, Cardiff & Vale University Health Board		20-22 March 2023	Inspection
11	Learning Disability service Betsi Cadwaladr University Health Board		22-23 March 2023	Inspection
12	HIW & CIW Joint Community Mental Health Team (CMHT) North Monmouthshire CMHT, Maindiff Court Hospital, Aneurin Bevan University Health Board		15-16 November 2022	Inspection
13	HIW & CIW Joint Community Mental Health Team (CMHT) Bridgend North CMHT, Maesteg Community Hospital, Cwm Taf Morgannwg University Health Board		13-14 December 2022	Inspection
14	HIW & CIW Joint Community Mental Health Team (CMHT) Welshpool CMHT, Bryntirion Mental Health Resource Centre, Victoria Memorial Hospital, Powys Teaching Health Board		14-15 February 2023	Inspection
	Independent Healthcare Providers			
15	Heatherwood Court Hospital Llantrisant Road, Pontypridd		21-23 June 2022	Inspection
16	Tŷ Grosvenor		25-27 April 2022	Inspection
17	Delfryn House and Delfryn Lodge		4-6 July 2022	Inspection
18	St Peter's Hospital		17-19 October 2022	Inspection
19	Heatherwood Court Hospital, Llantrisant Road, Pontypridd.		8-9 November 2022	Inspection
20	Llanarth Court Hospital		13-15 February 2023	Inspection
21	New Hall Independent Hospital		13-15 March 2023	Inspection
22	Hillview Hospital		15-17 August 2022	Inspection

Appendix B: Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also independent mental health advocate.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers.
CO2 form	Certificate of consent to treatment (Section 58(3) (a)).
CO3 form	Certificate of second opinion (Section 58(3) (b)).
CO7 form	Certificate of appropriateness of treatment to be given to a community patient.
CO8 form	Certificate of consent to treatment for a community patient.

Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory Treatment	Medical treatment for mental disorder given under the Act.
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned".
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.

Doctor	A registered medical practitioner.
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.

Leave of absence (section 17 leave)	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as 'Section 17 leave'.
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time.
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.
Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.

Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar. It is simply a reflection of the terminology used in the Act itself.
Prescribed body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.

Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49. The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually.
Section 12 doctor	See doctor approved under Section 12.
Section 17A	This is a Community Treatment Order.
Section 37	This is a hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function.
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.

Section 61	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B.
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights.
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety.
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts: **Part 1** – Primary mental health support services. **Part 2** – Co-ordination of and care planning for secondary mental health service users. **Part 3** – Assessment of former users of secondary mental health services. **Part 4** – Mental health advocacy.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Feedback on this report

If you have any comments or queries regarding this publication, please contact us.

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